PRINTED: 04/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILDING		COMPLETED	
		155145	A. BUILDING B. WING		03/17/2011	
				ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
NAME OF F	ROVIDER OR SUPPLIE	R		AST NATIONAL HIGHWAY		
WASHIN	GTON NURSING (CENTER	I	INGTON, IN47501		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0000	This visit was for (PSR) to the Re Licensure Survey of Complaint IN 01/27/11. This visit was in Investigation of Complaint IN00 Survey Date: Marcility Number Provider Number Provider Number Provider Number: Survey Team: Sharon Whitem Amy Wininger, Marla Potts, RN Census Bed Typ SNF: 12	r: 000068 er: 155145 100274980 an, RN TC RN	F0000	Submission of the Plan of Correction does not consitute admission to or an agreemen with facts alleged on the survice report. Submission of the plan correction does not constitute admission or an agreement be the provider of the truth of fact alleged or corrections set forth the statement of deficiencies. Facility respectfully request the granting of paper compliance therefore the supportive documentation will be added an attachement.	an t ey of an y tts h on The e ;	
	SNF/NF: 79					
	Total: 91					
	Census Payor T	ype:				
	Medicare: 13					
	Medicaid: 64					
	Other: 14					
	Total: 91					
	71					
				1		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

YQMT12

Facility ID:

000068

If continuation sheet

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155145	A. BUILDING B. WING		03/17/2011	
	PROVIDER OR SUPPLIER		603 EA	ADDRESS, CITY, STATE, ZIP CODE IST NATIONAL HIGHWAY INGTON, IN47501		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	REGULATORY OR Sample: 11 These deficiencie findings cited in 16.2.			CROSS-REFERENCED TO THE APPROPRIA	an t ey of an y ts h on The	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S	ETED	
		155145	B. WIN	G		03/17/20	011
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
\A\A OLUNI	OTON NI IDOING O	ENTED			ST NATIONAL HIGHWAY		
	GTON NURSING C			WASHI	INGTON, IN47501		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFY ING INFORMATION)	+	IAG)		DATE
F0225		ed on interview and record		25	Submission of this Plan of Correction does not constitute		03/31/2011
SS=D	review, the fac	cility failed to ensure			and admission or an agreemen		
	a resident's (Re	esident #A)			by the provider of the truth of		
	,	taff verbal and			facts alleged or corrections se	t	
	physical abuse				forth on the statement of deficiencies. The Plan of		
		_			Correction is prepared and		
	_	This affected 1 of 5			submitted because of		
	residents revie				requirements under State and		
	allegations in a	a sample of 11.			Federal law.Please accept this Plan of Correction as our cred		
					allegation of compliance.F225		
	Findings inclu	de·			ABUSE/NEGLECT REPORTE		
	1 111411185 111614				TO ADMINISTRATIONThe fac	ility	
		DNI (1) //2			will ensure this requirement is		
		PN (charge nurse) #2			met through the following corrective measures:1. Resid	lent	
	on 03/17/11 at	9:10 a.m. indicated			#A was not harmed.2. All		
	LPN #2 observ	ved therapy working			residents have the potential to	be	
	with Resident	#A on 03/09/11.			affected. Residents were interviewed as part of the facili	itv's	
	Therapy was a	ttempting to get the			investigation and no concerns	-	
	resident to star	nd. LPN #2 indicated			were noted at this time. 3. The	э	
	she (LPN #2) :	also was encouraging			Policy and Procedure for Resident Abuse and for Repor	ting	
	, ,	stand. LPN #2			Unusual Occurrences was	y	
		x #3 walked by, and			reviewed and no changes are	_	
		ointed to the CNA			indicated. The staff have beer re-educated on the policies an		
					procedures for reporting abuse		
	#(3) and said,	"There she is."			(See Attachment A). All		
					allegations of abuse will be	_	
	Interview of L	PN #2 on 03/17/11 at			reported immediately by staff the Administrator. One staff	٠	
	12:20 p.m. ind	licated on 03/09/11			member will be questioned by	the	
	_	ad eaten breakfast			Administrator or designee daily		
		re CNA #1 and CNA #3 sed the resident. LPN #2			on scheduled work days x4	_	
					weeks, then two times weekly weeks, and then twice monthly		
	toneted the res	SIQUIII. LPIN #2			thereafter to ensure continued		
			1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/17/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 603 EAST NATIONAL HIGHWAY WASHINGTON, IN47501		
WASHIN (X4) ID PREFIX TAG	summary s (EACH DEFICIENT REGULATORY OR indicated bread between 8:00 a resident was ta approximately indicated CNA toileted the res LPN #2 indicated standing nearb pointed and ac #2 indicated C anything to LF	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Refast was served and 9:00 a.m., and the aken to therapy at 10:00 a.m. LPN #2 A #1 and CNA #3 had reddent before therapy. A ted CNA #1 was not by when the resident acused CNA #3. LPN ANA #1 did not report ANA #1 did not report ANA #2 CNAS were aware			ring DATE blan 5.
	type of abuse is charge nurse a urgent as this" should report is am always her Resident #A) is some reason I know to report #2 indicated C work and take residents after #A. An investigation	resided and if for am not here they at it to someone. LPN NA #3 continued to care of other toileting Resident			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155145	B. WING		03/17/2011	
	PROVIDER OR SUPPLIER		603 EA	ADDRESS, CITY, STATE, ZIP CODE AST NATIONAL HIGHWAY		
	GTON NURSING C	ENIER	WASH	INGTON, IN47501		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI		ON
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	concerned, Re	esident (#A) confided				
	in me that (CN	NA #3) was being				
		is morning during				
		ADL (activities of				
	daily living) ca	are. (Resident #A)				
	stated to me 'th	nis morning when I				
		out of bed they				
		as and that (CNA #3)				
	said Jes Chr-	, if you don't do it				
	now you never	r will.' I asked				
	,	if her belt (gait belt)				
	was on and sh	e said 'yes but the				
	(sic) still pull	on my arms				
	especially that	one' (points to CNA				
	#3). 'When I w	vas in the wash room				
	this morning the	hey were again				
	pulling on my	arms and I keep				
	telling them it	hurts' (sic) (Resident				
	#A) could not	state (CNA #3's)				
	name but when	n passed her in the				
	hall she pointe	ed at her and said 'see				
	there she goes	, get her away from				
	me, I'm afraid	of her.'" This				
	statement was	signed by LPN #2				
	(Charge Nurse	on the hall where				
	Resident #A re	esided).				
	Interview of th	ne Administrator on				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					ONSTRUCTION	(X3) DATE S	
1111212111	or conditions	155145	A. BUI B. WIN	LDING		03/17/2	
NAME OF I	DROLUDED OD CLUDDI IED		p. wiiv		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			1	ST NATIONAL HIGHWAY		
WASHIN	GTON NURSING C	ENTER		WASHI	NGTON, IN47501		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	` ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	3/17/11 at 11:4	10 a.m. indicated					
	CNA #3 was r	eleased for					
	unprofessional	l behavior.					
	•						
	Interview of S	peech Therapist #4					
	on 03/17/11 at	10:20 a.m. indicated					
	Resident #A w	as brought to Speech					
	Therapist #4 a	fter being toileted.					
	Speech Therap	oist #4 indicated, "I					
	could tell (Res	sident #A) was a little					
	upset. I asked	if she (Resident #A)					
	was ok and (R	esident #A) said that					
	nurse and desc	cribed her and I knew					
	who it was by	the description and					
	then (Resident	#A) said, "Can I					
	write a report	if there is a sheet."					
	Speech Therap	oist #4 indicated to					
	the resident the	at she would help her					
	with the report	t. Speech Therapist					
	#4 indicated th	nat she wrote exactly					
	what the reside	ent said that (CNA					
	#3) hurt her (u	pper) arm and talked					
	mean to her. S	Speech Therapist #4					
	indicated CNA	A #3 walked by and					
	_	ointed at CNA #3 and					
	said,"there she	e is." Speech					
	Therapist #4 ii	ndicated she went					
	immediately to	her supervisor and					
					1		

l	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155145	A. BUI	LDING		COMPLETED 03/17/2011	
		155145	B. WIN		DDDEGG GITW GTATE ZID GODE	03/17/2	011
NAME OF I	PROVIDER OR SUPPLIER	R		1	ADDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY		
	GTON NURSING C	ENTER		WASHII	NGTON, IN47501		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	her supervisor						
	reported to the	e charge nurse and the					
	charge nurse v	vent immediately to					
	CNA #3. Spec	ech Therapist #4					
	indicated she	then went to lunch					
	and when she	returned CNA #3 was					
	out of the buil	ding. Speech					
	Therapist #4 is	ndicated the resident					
	told her that sl	he told CNA #3 she					
	was too weak	to stand up and CNA					
	#3 said, "yes y	ou can, yes you can."					
	A copy of a "C	Concern Form" was					
		ne DON on 03/17/11					
	at 11:00 a.m.	This form indicated,					
	"PT (Resident	#A) requested assist					
	from ST (Spee	ech Therapy) to fill					
	out formCo	ncern: Pt (Resident					
	#A) C/O (com	plained of) nursing					
	aid grabbing h	ner by arms &					
		onto toilet & 'talking					
	mean.' C/O pa	ain on (right) upper					
	_	e was 'grabbed.' Pt					
		ember says 'Stand Up'!					
		o it! Pt states she has					
	* *	legs are very weak &					
	1 ^	vill buckle. Pt was					
	1	crying & states this					
		<i>, ,</i>					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
THIDTEM	or conduction	155145		LDING		03/17/2011		
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	ļ		
NAME OF F	PROVIDER OR SUPPLIER				ST NATIONAL HIGHWAY			
WASHIN	GTON NURSING C	ENTER		WASHII	NGTON, IN47501			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
	happens 'over	& over' & believes						
	'action' needs t							
	Department's response: Listen to							
	patient's (Resid	-						
	complaints. R	eported to						
	department nu	rse & rehab						
	managerPt u	nable to state aid's						
	name but wa	s able to describe and						
	point out speci	ific aid."						
		hysical Therapy						
	`	A) #5 on 03/17/11 at						
		icated, the only thing						
		of was when staff						
	_	valk Resident #A the						
		want to walk. PTA						
		ne resident had						
	*	en progressing well.						
		ted CNA#3 walked						
	~	nt #A said, "There						
	[ne is, she doesn't want						
	to help me."							
	Interview of C	lartified Occupation						
		Certified Occupation						
		tant (COTA) #6 on :30 a.m. indicated the						
		een toileted and then						
	came to therap	y. CO1A#0						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/17/2011	
NAME OF I	PROVIDER OR SUPPLIEI	" ?	•	1	ADDRESS, CITY, STATE, ZIP CODE	•	
WASHIN	GTON NURSING (CENTER	603 EAST NATIONAL HIGHWAY WASHINGTON, IN47501				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	indicated Resi	ident #A told her,					
	"Oh, honey th	at girl was mean. She					
	talked mean &	t she hurt my arm.					
	They need to	give me more time."					
	COTA #6 indi	cated she asked					
	Resident #A v	vho she was talking					
	about and ask	ed her to give some					
	examples. CO	OTA #6 indicated the					
	resident said '	she pulled my arm."					
	COTA #6 indi	cated the resident					
	described who	the "girl" was.					
	COTA #6 indi	cated she tried to					
	walk the resid	ent and the resident					
	stood up and	CNA #3 walked by					
	and the reside	nt indicated, "Oh my					
	G-d honey the	ere she is. She's the					
	one." COTA	#6 indicated the					
	resident was t	hen taken back to her					
	room.						
	An investigati	ve sheet, dated					
	1	cated, "On this date,					
	•	reported some					
	· '	ter the CNAs toileted					
	_	dent #A) stated 'that					
	,	rough with me and					
		me by my arms.					
	1	hese statements					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI A. BUII		NSTRUCTION		(X3) DATE SURVEY COMPLETED	
		155145	B. WIN	G			03/17/2	011
NAME OF F	PROVIDER OR SUPPLIER	\ \			DDRESS, CITY, STATE,			
WASHIN	GTON NURSING C	ENTER			ST NATIONAL HIGI NGTON, IN47501	HWAY		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN	OF COPPECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE O THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIEN	ICY)		DATE
		was in the hallway to						
	`	NA#3) walked down						
	the hall and (Resident #A) started							
	pointing saying 'there she is, that's							
	her!' This incident was in the							
	presence of (C	COTA #6, ST #4, PTA						
	#5, and LPN #	2). Up to this date						
	(Resident #A)	had been able to						
	(walk) 20 ft, h	owever was so upset						
	and fearful tha	at therapist would hurt						
	her (sic) also s	she required max						
	assist of 2 to s	tand and unable to						
	(walk). (Resid	dent #A) reported to						
		she would like to talk						
	•	out these concerns.						
		sted (Resident #A) in						
	filling out cone	,						
		hab nurse (LPN #2)."						
	reported to Ke	mao marse (El 14 #2).						
	Interview of th	ne Director of						
		V) on 03/17/11 at						
	O (licated CNA #3 had a						
		ent with a gentleman						
	-	ferred to another						
		was a "he said, she						
	-	ot validated. The						
	DON indicated							
		ne past where she						
	proofeins in th	ic past where sile						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	YQMT12	Facility II	D: 000068	If continuation s	heet Pa	ge 10 of 43

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155145	B. WING				03/17/2	011
NAME OF F	PROVIDER OR SUPPLIER		'	STREET A	DDRESS, CITY, STATE, ZIF	CODE		
					ST NATIONAL HIGHV	VAY		
	GTON NURSING C				IGTON, IN47501			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO			(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE DEFICIENCY		ΓE	DATE
	would be mou	thy with staff in front						
	of the resident	s, but would be						
	counseled and	then "would settle						
	down." The D	OON indicated, "This						
	is the first time	e I've had a resident						
	point someone	out to me and say,						
	"she did this."	The DON indicated						
	the abuse occu	irred in the shower						
	room and CNA	A #1 was present						
	when it happer	ned. The DON						
	indicated CNA	A #1 did not report the						
	abuse. The Do	ON indicated therapy						
	came to her an	d reported what the						
	resident said.	The DON indicated						
	she was told by	y CNA #1 that the						
	CNA said she	was afraid to report						
	what happened	d. The DON						
	indicated the r	esident was confused						
	but she told the	e same story 3 times.						
	The DON indi	cated the resident had						
	a bruise on her	r arm which looked						
	like a "hand pr	rint" bruise. The						
	_	d the CNA #3 denied						
	it (Resident #A	A's allegation) but "I						
	felt like it prob	pably happened."						
	The DON indi	cated she notified the						
	Adult Protective	ve Services (APS),						
	the Ombudsma	an, and ISDH, but did						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	YQMT12	Facility II	D: 000068 If o	continuation sl	heet Pa	ge 11 of 43

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		A. BUII	DING	NSTRUCTION	CO	(X3) DATE SURVEY COMPLETED 03/17/2011		
		100110	B. WIN		DDRESS, CITY, STATE, ZIP	_		
NAME OF F	PROVIDER OR SUPPLIER	1			ST NATIONAL HIGHW			
WASHIN	GTON NURSING C	ENTER		WASHIN	NGTON, IN47501			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	IE APPROPRIATE	COMPLETION DATE	
1710		occurrence to the		mo	<u> </u>		DATE	
	-	The DON indicated						
		right to her (the						
		IA #3 was brought to						
	her also and clocked out. The DON							
		dent #A required a lot						
		rom staff and was						
		by the afternoon the						
		not remember what						
		when asked if she						
	was afraid of anything she said							
		rl." The DON						
		pression scale was						
		Resident #A that						
	•	her depression scale						
	had increased	-						
	depression sca							
	*	verbally told CNA #1						
		d always report any						
		ation of abuse to her						
	_	The DON indicated						
	_) had gone to CNA #1						
	` ´	g regarding the						
	_	gation. The DON						
	_	CNA had not told						
	anyone.							
	Interview of C	CNA #1 on 03/17/11 at						
FORM CMS-2	2567(02-99) Previous Versio	ons Obsolete Event ID:	YQMT12	Facility I	D: 000068 If c	continuation sheet	 Page 12 of 43	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY COMPLETED	
	2.2	155145	A. BUII				03/17/2		
			B. WIN		DDRESS, CITY, STATE, 2	ZIP CODE	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIEI	R		1	ST NATIONAL HIGH				
WASHIN	GTON NURSING (CENTER	WASHINGTON, IN47501						
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN O			(X5)	
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	THE APPROPRIAT	ΓE	COMPLETION DATE	
		cated, "Me (CNA #1)							
	and (CNA #3)	· · · · · · · · · · · · · · · · · · ·							
	· ` ` ′	to the bathroom and							
	(CNA #3) was	s yanking on							
	(Resident #A)	with the gait belt.							
	(CNA #3) wei	nt to (answer) an							
	alarm and wh	en she came back -							
	she point blan	k told (Resident #A)							
	to 'stand her F	ug a-s up.' Then							
	she (CNA #3)	told the resident she							
	could stand up	and pull her pants							
	up herself. C	NA #1 indicated after							
	toileting the re	esident, she took the							
	resident (in th	e resident's							
	wheelchair) b	ack to the nurse's							
	station. (The r	nurse's station is an							
	enclosed area	with a window in the							
	front.) CNA#	3 indicated the nurse							
	(LPN #2) "wa	s in there but							
	someone was	with her." CNA #3							
	indicated she	did not report the							
	occurrence to	the nurse but told the							
	resident to tell	I the nurse.							
	1	ive sheet (not dated)							
		CNA #1) was in the							
	`	CNA#3) when (CNA							
	#3) told (Resi	dent #A) she was							
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete Event ID:	YQMT12	Pacility II	D: 000068	If continuation s	heet Pa	ge 13 of 43	

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPI	LETED
		155145	B. WI			03/17/2	011
	PROVIDER OR SUPPLIER		•	603 EAS	DDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY NGTON, IN47501	•	
					NOTOIN, IIN+1 JUT		775
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	0 0	a hold of the gait belt					
		did (Resident #A)					
	· '	use) she (CNA #3)					
		ot. So then (CNA #3)					
		d said she was tired of					
		in (sic) her like sh-t					
		ways get the blame					
		Also she (CNA #3)					
	,	#A) on our second					
	_	nd her up that we					
	_	her stand (sic) we					
	1	and hold onto the					
	~	(CNA #3) said we					
		ing time for this					
		ve other people to get					
	_	d her (Resident #A)					
	_	sat her down again.					
	' '	up, pull up her pants,					
	and to get into	her chair by herself,					
	since she (Res	ident #A) thinks she					
	can do everyth	ing herself! Then					
	she said she di	dn't have times (sic)					
	for games so v	ve stood her up and					
	pulled up her p	pants and put her in					
	her chair! So t	hen we took her out					
	for breakfast.	After we transferred					
	her (Resident a	#A) to the toilet (sic)					
	(CNA #3) left	(Resident #A) in the					
		•					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE O A. BUILDING B. WING	CONSTRUCTION	li i	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER		603 E	raddress, city, state, zip code AST NATIONAL HIGHWAY HINGTON, IN47501		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR bathroom with	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) me (CNA #1) for a e she had to answer	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	an alarm and (me (why) (CN way towards h was hateful. I really didn't kr should tell her doesn't treat he wasn't fair to h doesn't derserv bad." Copies of inverelated to the of 03/09/11 with Resident #A w DON on 03/17 Interview of L 1:50 p.m. indicated the opportunity took place with Resident #A). she (LPN #2) indicated if she the CNA should	Resident #A) asked (A#3) was always this er and how come she (CNA #1) told her I now but that she nurse when someone er right because that her and that she we (sic) to be treated estigative sheets occurrence on CNA #3 and here provided by the 1/11 at 11:00 a.m. PN #2 on 03/17/11 at cated, "(CNA#1) had by to tell me (what				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/17/2011				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 603 EAST NATIONAL HIGHWAY WASHINGTON, IN47501					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
	the resident to indicated she a encourage the Resident #3 kd I'm afraid.' LI CNA#3 had be other residents (Resident #A) pointed out to she was afraid Interview of R 03/17/11 at 12 resident's care resident was sthe time of the resident indicate "girl" who "talterrible words mouthshe we came in. She attitude." The told and they for take this review. The resident indicate it." The resident indicate it." The resident indicate it.	as attempting to get stand. LPN #2 also was trying to resident to stand and ept saying 'I'm afraid, PN #2 indicated een taking care of and walked by and the resident (CNA #3) and said of this CNA.						

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIPLE CO LDING	INSTRUCTION		COMPLETED	
		155145	A. BUI B. WIN		-		03/17/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STAT	ΓE, ZIP CODE	-	
				1	ST NATIONAL H			
	GTON NURSING C			<u>. </u>	NGTON, IN4750 ⁻	ı		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	(EACH CORRECTIVE	AN OF CORRECTION E ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCE DEFI	D TO THE APPROPRIA CIENCY)	TE	DATE
	nice."							
	A copy of a "F	AX/INCIDENT						
	REPORT" for	m was provided by						
	the DON on 03	3/17/11 at 11:00 a.m						
	This report inc	licated, "Incident						
	Date - 03/06/1	1Staff noted a						
	bruise approxi	mately 14x11 cm						
	(centimeters)	on resident's upper						
	left arm during	g care. Resident was						
	admitted on 1/	22/11 with edema,						
	severe/extensi	ve bruising, a						
	fractured left h	numerus (arm), and a						
	fractured left h	nip as a result of a fall						
		sion. The resident is						
	alert with shor	t term memory						
	impairment an	d occasional						
	confusion. Up	oon interview,						
	resident denies	s any injury to left						
		ninistrator and						
	Director of Nu	irsing were notified						
		Physician and family.						
		as assessed for pain.						
		staff working on this						
		iated. In speaking						
		y, they stated that						
	· ·	bruises very easily						
	l ` ´	s done so. Preventive						
FORM CMS-2	2567(02-99) Previous Versio	ons Obsolete Event ID:	YQMT12	2 Facility I	ID: 000068	If continuation s	heet Pa	ge 17 of 43

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/17/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 603 EAST NATIONAL HIGHWAY WASHINGTON, IN47501				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
		en: The Director of signee will monitor					
	1	e resident and speak					
	Occupational 7	Therapy to try to					
		use. The resident is (complete blood					
		ray done on 3/7/11.					
	This report cop Report."	py was the "initial					
	REPORT" form the DON on 0.00. This report was above incident report had add which included investigation preported that of 'rough' with he arms to transfer arms and resid was uncomfor Q.M.A. (Quality Assistant) (CN QMA) providi	period, resident one employee was er and had used her er her causing pain in dent stated that she table with this					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		155145	B. WIN				03/17/2	011	
NAME OF F	DOMINED OF CURRY ICA		1		DDRESS, CITY, STATE, ZIF	CODE	L		
	PROVIDER OR SUPPLIER				ST NATIONAL HIGHV	VAY			
	GTON NURSING C	ENTER		WASHIN	NGTON, IN47501				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO			(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE DEFICIENCY	HE APPROPRIAT	ΤE	DATE	
	on the morning	g of 3/9/11. Further							
	investigation is								
	allegation directly correlates with								
	the bruise on 1								
		physical therapy,							
		nd co-worker were							
	_	This report copy was							
	the "Follow-up	p Report."							
	A copy of a for	rm titled "NOTICE							
	OF DISCIPLI	NARY ACTION,"							
	dated 03/09/11	, indicated							
	termination of	CNA #3. The form							
	indicated, "#	1 Repeated							
	allegation of v	erbal et (and)							
	physical misco	onduct toward							
	resident causir	ng fear from resident.							
	List of prior w	ritten warnings on							
	file and date.	6/3/08 - attitude,							
	2/9/11Failur	e to comply with							
	other expectati	ions for performance							
	et behavior set	forth in employee							
	Handbook.								
	Unprofessiona	l/inappropriate							
	behavior arour	nd residents (with)							
	understanding	that further incidents							
	may result in t	ermination. Describe							
	in detail inform	nation you have							
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	YQMT12	Facility II	D: 000068 If o	continuation sl	heet Pa	ge 19 of 43	

PRINTED: 04/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/17/2011			
	PROVIDER OR SUPPLIER		B. WING GS/17/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 603 EAST NATIONAL HIGHWAY WASHINGTON, IN47501				
WASHIN (X4) ID PREFIX TAG	Review of Resrecord on 03/1 indicated the findled, but we chronic obstructions of falls 1/19/11, periph disease, chronintra cerebral to the status was more resident.	tatement of deficiencies cy Must be perceded by full LSC IDENTIFYING INFORMATION) h supports taking the of action(Resident ons of physical et priateness (with) currently having new the tarm. Resident of employee" sident #A's clinical 7/11 at 11:25 a.m. following: ad diagnoses which were not limited to, cetive pulmonary arthritis, dementia, a, left hip fracture meral vascular nic oxygen use, and oleed.			BE COMPLETION		
	and toileting.						

000068

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145			LDING	NSTRUCTION	(X3) DATE S COMPL 03/17/20	ETED	
NAME OF 1	PROVIDER OR SUPPLIE	R.	•		ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING (CENTER		1	ST NATIONAL HIGHWAY NGTON, IN47501		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· `	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	KEGGE/HOKT OF	CESC IDENTIFICATION ON THE ONLY		1110			DATE
	A copy of a po	olicy titled "Hoosier					
	Enterprises Procedure Resident						
	Abuse" was p	rovided by the DON					
	on 03/17/11 a	t 11:00 a.m. This					
	policy indicat	ed, "Purpose: To					
	assure approp	riate interventions are					
	in place and for	ollowed if resident					
	abuse is suspe	ected or					
	identifiedPr	ocedure: If resident					
	abuse, or susp	oicion of abuse is					
	reported: 1.	The resident(s)					
	involved in th	e incident will be					
	removed from	the situation at					
	onceThe inc	lividual who					
	witnessed the	incident shall					
	immediately r	notify a charge nurse					
	of the nursing	unit which the					
	resident occup	pies. If this is not					
	feasible due to	o circumstances, the					
	individual sha	ll be responsible to					
	notify any oth	er nurse currently on					
	duty. The cha	arge nurse will					
	examine the re	esident involved to					
	determine if p	hysical injuries have					
	occurred and	their extent. The					
	charge nurse i	s responsible to notify					
	the facility Ac	lministrator and					
	<u> </u>						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMP 03/17/2	LETED	
	PROVIDER OR SUPPLIER GTON NURSING C		603 EA	ADDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY NGTON, IN47501		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	implicated in the be removed fronce and will until an invest completed"	Any staff member the alleged abuse will om the facility at remain suspended igation is				

PRINTED: 04/13/2011 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/17/2011		
WASHINGTON NURSING CENTER WASHINGTON, IN47501			 	B. WIN	STREET A	ST NATIONAL HIGHWAY	00/11/2	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE:	(X4) ID PREFIX TAG F0226	SUMMARY S (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	F02.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) F226 DEVELOP/IMPLEMENT POLICIES/PROCEDURES PREVENT MISTREATMENT/NEGLECT/LUSEThe facility will ensure this requirement is met through the following corrective measures Resident #A was not harmed All residents have the potential be affected. Residents were interviewed as part of the facility exiting and no concerns were noted at this time. 3. The Policy and Procedure for Resident Abuse and for Report Unusual Occurrences was reviewed and no changes are indicated. The staff have bee re-educated on the policies are procedures for reporting abus (See Attachment A). All allegations of abuse will be reported immediately by staff the Administrator. One staff member will be questioned by Administrator or his designee daily on scheduled work days weeks, then two times weekly weeks, and then twice monthal thereafter to ensure continued compliance (See Attachment B).4. The findings of these interviews will be reviewed duthe facility's quarterly Quality Assurance Meetings and the pof action adjusted accordingly The above corrective measure will be completed on or before will be completed on or	AB se :122al to ity's e rting nd e to the x4 x 4 y l ring plan .5. es	(X5) COMPLETION DATE 03/31/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YQMT12 Facility ID:

000068

If continuation sheet

Page 23 of 43

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S COMPL	
		155145	B. WIN			03/17/2	011
WASHIN	PROVIDER OR SUPPLIER	ENTER		STREET A 603 EA WASHI	ADDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY NGTON, IN47501		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0226		view and record	F02	26	F226 DEVELOP/IMPLEMENT POLICIES/PROCEDURES	'	03/31/2011
SS=D	review, the fac	cility failed to ensure			PREVENT		
	a resident's (Re	· ·			MISTREATMENT/NEGLECT// USEThe facility will ensure this		
	allegation of st	taff verbal and			requirement is met through the		
	physical abuse	was reported			following corrective measures:		
		ccording to facility			Resident #A was not harmed.	2.	
	-	cocedures. This			All residents have the potentia be affected. Residents were	י נט	
		residents reviewed			interviewed as part of the facili	ty's	
					investigation and no concerns	,	
	for abuse alleg	gations in a sample of			were noted at this time. 3. The	Э	
	11.				Policy and Procedure for		
					Resident Abuse and for Repor	ting	
	Eindings inclu	da:			Unusual Occurrences was reviewed and no changes are		
	Findings inclu	de.			indicated. The staff have beer	n	
					re-educated on the policies an		
	Interview of L	PN (charge nurse) #2			procedures for reporting abuse	e	
	on 03/17/11 at	9:10 a.m. indicated			(See Attachment A). All		
	LPN #2 observ	ved therapy working			allegations of abuse will be reported immediately by staff t	_	
		#A on 03/09/11.			the Administrator. One staff		
					member will be questioned by	the	
	~ ~	ttempting to get the			Administrator or his designee		
	resident to star	nd. LPN #2 indicated			daily on scheduled work days		
	she (LPN #2) a	also was encouraging			weeks, then two times weekly weeks, and then twice monthly		
	` ′	stand. LPN #2			thereafter to ensure continued	′	
					compliance (See Attachment		
		x #3 walked by, and			B).4. The findings of these		
	Resident #A p	ointed to the CNA			interviews will be reviewed dur	ing	
	#(3) and said,	"There she is."			the facility's quarterly Quality	lan	
					Assurance Meetings and the p of action adjusted accordingly.		
	Interview of L	PN #2 on 03/17/11 at			The above corrective measure	s	
	12·20 n m ind	licated on 03/09/11			will be completed on or before		
	•				3/31/11.		
	Kesident #A h	ad eaten breakfast					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		NSTRUCTION		(X3) DATE SURVEY COMPLETED		
		155145	B. WING		_		03/17/2011	
NAME OF F	PROVIDER OR SUPPLIER		'		DDRESS, CITY, STATE, ZIP			
WASHIN	GTON NURSING C	ENTER		WASHINGTON, IN47501				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
	before CNA#			-				
	toileted the res	sident. LPN #2						
	indicated brea	kfast was served						
	between 8:00	and 9:00 a.m., and the						
	resident was ta	aken to therapy at						
	approximately	10:00 a.m. LPN #2						
	indicated CNA	A #1 and CNA #3 had						
	toileted the res	sident before therapy.						
	LPN #2 indica	ated CNA #1 was not						
	standing nearb	y when the resident						
	pointed and ac	cused CNA #3. LPN						
	#2 indicated C	NA #1 did not report						
	anything to LI	PN #2. LPN #2						
	indicated the (CNAs were aware						
	they were supp	posed to report any						
	type of abuse	immediately to the						
	charge nurse a	nd "for something as						
	urgent as this"	they definitely						
	should report	it. LPN #2 said, "I						
	am always her	e (on the unit						
	Resident #A)	resided and if for						
	some reason I	am not here they						
	know to repor	t it to someone. LPN						
	#2 indicated C	CNA #3 continued to						
	work and take	care of other						
	residents after	toileting Resident						
	#A.							
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	YQMT12	Facility I	D: 000068 If c	continuation sheet	Page 25 of 43	

PRINTED: 04/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155145	l l	A. BUILDING			/2011
		100140	B. WING		ADDRESS, CITY, STATE, ZIP CODE	00/1//	2011
NAME OF I	PROVIDER OR SUPPLIEF				ST NATIONAL HIGHWAY		
WASHIN	GTON NURSING C	ENTER	WASHINGTON, IN47501				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5)
PREFIX TAG	· ·	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
		ve sheet, dated					
		cated, "To whom					
	concerned, Re	esident (#A) confided					
		NA #3) was being					
	mean to her th	is morning during					
	transfers and A	ADL (activities of					
	daily living) c	are. (Resident #A)					
	stated to me 't	his morning when I					
	was getting up	out of bed they					
	pulled my arm	ns and that (CNA #3)					
	said Jes Chr-	, if you don't do it					
	now you neve	r will.' I asked					
	(Resident #A)	if her belt (gait belt)					
	was on and sh	e said 'yes but the					
	(sic) still pull	on my arms					
	especially that	one' (points to CNA					
	#3). 'When I w	vas in the wash room					
	this morning t	hey were again					
	1	arms and I keep					
	telling them it	hurts' (sic) (Resident					
	l '	state (CNA #3's)					
		n passed her in the					
	_	ed at her and said 'see					
	_	, get her away from					
	me, I'm afraid						
		signed by LPN #2					
		e on the hall where					
	Resident #A re	esided).					
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	YQMT12	Facility I	ID: 000068 If continuat	ion sheet P	age 26 of 43

YQMT12 Facility ID:

Page 26 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	155145	A. BUII			03/17/2011		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		-	
NAME OF I	PROVIDER OR SUPPLIER				ST NATIONAL HIGHWAY			
WASHIN	GTON NURSING C	ENTER		WASHII	NGTON, IN47501			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF C			(X5)	
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION DATE		
1710	REGUERIORI OR	ESC IDENTIFICATION ORGANIZATION		1710			Ditte	
	Interview of th	ne Administrator on						
		40 a.m. indicated						
	CNA #3 was re	eleased for						
	unprofessional	l behavior.						
	•							
	Interview of S	peech Therapist #4						
	on 03/17/11 at	10:20 a.m. indicated						
	Resident #A w	as brought to Speech						
	Therapist #4 a	fter being toileted.						
	Speech Therap	oist #4 indicated, "I						
	could tell (Res	ident #A) was a little						
	upset. I asked	if she (Resident #A)						
	was ok and (R	esident #A) said that						
	nurse and desc	cribed her and I knew						
	who it was by	the description and						
	then (Resident	:#A) said, "Can I						
	write a report i	if there is a sheet."						
	Speech Therap	oist #4 indicated to						
	the resident tha	at she would help her						
	with the report	t. Speech Therapist						
	#4 indicated th	nat she wrote exactly						
	what the reside	ent said that (CNA						
		pper) arm and talked						
		Speech Therapist #4						
		A #3 walked by and						
		ointed at CNA #3 and						
	said,"there she							
	•	•						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/17/2011		
	PROVIDER OR SUPPLIER		603 EA	ADDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY NGTON, IN47501	'	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Therapist #4 in immediately to her supervisor reported to the charge nurse we CNA #3. Special indicated she to and when she out of the build. Therapist #4 in told her that she was too weak #3 said, "yes yes." A copy of a "Coprovided by the at 11:00 a.m. "PT (Resident from ST (Special from ST (ndicated she went o her supervisor and immediately c charge nurse and the vent immediately to ech Therapist #4 then went to lunch returned CNA #3 was ding. Speech indicated the resident ne told CNA #3 she to stand up and CNA rou can, yes you can." Concern Form" was the DON on 03/17/11 This form indicated, #A) requested assist ech Therapy) to fill incern: Pt (Resident plained of) nursing	1		RIATE	
		legs are very weak &				

PRINTED: 04/13/2011 FORM APPROVED OMB NO. 0938-0391

		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155145	B. WIN			03/17/2011	
NAME OF I	PROVIDER OR SUPPLIER	1		1	ADDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY		
WASHIN	GTON NURSING C	ENTER		1	NGTON, IN47501		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)		ATE COMPLETION DATE	
		vill buckle. Pt was		_			
	emotional and	crying & states this					
	happens 'over	& over' & believes					
	'action' needs t	to take place.					
	Department's 1	response: Listen to					
	patient's (Resi	dent #A's)					
	complaints. R	eported to					
	department nu	rse & rehab					
	managerPt u	nable to state aid's					
	name but wa	s able to describe and					
	point out speci	ific aid."					
	Interview of P	hysical Therapy					
	Assistant (PTA	A) #5 on 03/17/11 at					
	`	licated, the only thing					
		of was when staff					
	attempted to w	valk Resident #A the					
	_	want to walk. PTA					
		ne resident had					
		en progressing well.					
		ted CNA#3 walked					
		nt #A said, "There					
	1	ne is, she doesn't want					
	to help me."	io 15, blie doesli t walit					
	to help life.						
	Interview of C	Certified Occupation					
		tant (COTA) #6 on					
	1	:30 a.m. indicated the					
	05/17/11 41 10	.5 0 d.iii. iiidioatod tiio					

000068

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/17/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 603 EAST NATIONAL HIGHWAY WASHINGTON, IN47501				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	resident had be came to therapindicated Resimindicated Resimindicated Resimindicated Resimindicated Resimindicated Resimindicated Resimindicated Resimindicated Resimindicated Resident & COTA #6 individes Resident #A was about and asked examples. Compared to a compared	een toileted and then by. COTA #6 dent #A told her, at girl was mean. She she hurt my arm. give me more time." cated she asked who she was talking ed her to give some OTA #6 indicated the she pulled my arm." cated the resident the "girl" was. cated she tried to ent and the resident CNA #3 walked by nt indicated, "Oh my re she is. She's the #6 indicated the nen taken back to her ve sheet, dated cated, "On this date, reported some er the CNAs toileted dent #A) stated 'that			CROSS-REFERENCED TO THE APPROPRIA	TE	
	0110 4140 10 00	rough with me and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		A. BUILI	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/17/2011		
		100170	B. WING		DDDEGG GUTY GT TT	ZID CODE	00/11/2	
NAME OF I	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE T NATIONAL HIC			
	GTON NURSING C	ENTER	WASHINGTON, IN47501					
(X4) ID		TATEMENT OF DEFICIENCIES		ID		N OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	REFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED DEFICI	TO THE APPROPRIAT	E	COMPLETION DATE
		ne by my arms.						
		hese statements						
	(Resident #A)	was in the hallway to						
	ambulate. (Cl	NA#3) walked down						
	the hall and (R	Resident #A) started						
	pointing sayin	g 'there she is, that's						
	her!' This inc	ident was in the						
	presence of (C	COTA #6, ST #4, PTA						
	#5, and LPN #	(2). Up to this date						
	(Resident #A)	had been able to						
	(walk) 20 ft, h	owever was so upset						
	and fearful tha	at therapist would hurt						
	her (sic) also s	she required max						
	assist of 2 to s	tand and unable to						
	(walk). (Resid	dent #A) reported to						
	therapists that	she would like to talk						
	to someone ab	out these concerns.						
	Therapist assis	sted (Resident #A) in						
	filling out con	cern form and						
	reported to Re	hab nurse (LPN #2)."						
	Interview of the							
	· ·	V) on 03/17/11 at						
		licated CNA #3 had a						
	_	ent with a gentleman						
	who was trans	ferred to another						
	facility but it v	was a "he said, she						
	said" so was n	ot validated. The						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	YQMT12	Facility II	D: 000068	If continuation sl	neet Pa	ge 31 of 43

A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE	011
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
603 EAST NATIONAL HIGHWAY	
WASHINGTON NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID SUMMARY STATEMENT OF DEFICIENCIES	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
DON indicated CNA #3 had	
problems in the past where she	
would be mouthy with staff in front	
of the residents, but would be	
counseled and then "would settle	
down." The DON indicated, "This	
is the first time I've had a resident	
point someone out to me and say,	
"she did this." The DON indicated	
the abuse occurred in the shower	
room and CNA #1 was present	
when it happened. The DON	
indicated CNA #1 did not report the	
abuse. The DON indicated therapy	
came to her and reported what the	
resident said. The DON indicated	
she was told by CNA #1 that the	
CNA said she was afraid to report	
what happened. The DON	
indicated the resident was confused	
but she told the same story 3 times.	
The DON indicated the resident had	
a bruise on her arm which looked	
like a "hand print" bruise. The	
DON indicated the CNA #3 denied	
it (Resident #A's allegation) but "I	
felt like it probably happened."	
The DON indicated she notified the	

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BU			MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		155145	B. WIN	_		03/17/20	U11	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
WASHIN	GTON NURSING C	ENTER		1	ST NATIONAL HIGHWAY NGTON, IN47501			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE	
1710		ve Services (APS),	-	ING	·		DATE	
		an, and ISDH, but did						
		occurrence to the						
	_	The DON indicated						
		right to her (the						
	1 1	A #3 was brought to						
	ĺ	ocked out. The DON						
		dent #A required a lot						
		rom staff and was						
		by the afternoon the						
		not remember what						
		when asked if she						
		nything she said						
	"only that 1 gi							
	'	pression scale was						
	_	Resident #A that						
	_	her depression scale						
	had increased	•						
	depression sca	le. The DON						
	_	verbally told CNA #1						
		d always report any						
		ation of abuse to her						
	_	The DON indicated						
	_	had gone to CNA #1						
	for questioning	g regarding the						
	resident's alleg	gation. The DON						
	indicated the C	CNA had not told						
	anyone.							

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING B. WING			(X3) DATE S COMPL 03/17/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u>"</u> {			ADDRESS, CITY, STATE, ZIP CODE		
WASHIN	GTON NURSING C	ENTER		1	ST NATIONAL HIGHWAY NGTON, IN47501		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORR DD FETY (EACH CORRECTIVE ACTION SHO			
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	Interview of C 2:05 p.m. indi and (CNA #3) (Resident #A) (CNA #3) was (Resident #A) (CNA #3) wer alarm and who she point blan to 'stand her F she (CNA #3) could stand up up herself. Cr toileting the re resident (in th wheelchair) be station. (The re enclosed area front.) CNA# (LPN #2) "was someone was indicated she occurrence to resident to tell An investigati	CNA #1 on 03/17/11 at cated, "Me (CNA #1) were taking to the bathroom and syanking on with the gait belt. In to (answer) an en she came back - k told (Resident #A) ug a-s up.' Then told the resident she of and pull her pants NA #1 indicated after esident, she took the eresident's fack to the nurse's nurse's station is an with a window in the 3 indicated the nurse in there but with her." CNA #3 did not report the the nurse but told the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/17/2011	
		155145	B. WING		03/17/2011
	PROVIDER OR SUPPLIER		603 EA	ADDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY NGTON, IN47501	
				1401014, 11447301	(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	DATE
	shower with (CNA#3) when (CNA			
	#3) told (Resid	dent #A) she was			
	going to grab	a hold of the gait belt			
	and when she	did (Resident #A)			
	had a fit (beca	use) she (CNA #3)			
	moved her foc	ot. So then (CNA #3)			
	stood back and	d said she was tired of			
	residents treat	in (sic) her like sh-t			
	and that we al	ways get the blame			
		. Also she (CNA #3)			
	told (Resident	#A) on our second			
	attempt to star	nd her up that we			
	could not help	her stand (sic) we			
	could only use	e and hold onto the			
	gait belt. She	(CNA #3) said we			
	don't have fu	ing time for this			
	because we ha	we other people to get			
	up. So she tol	d her (Resident #A)			
	again after we	sat her down again.			
	(sic) To stand	up, pull up her pants,			
	and to get into	her chair by herself,			
	since she (Res	ident #A) thinks she			
	can do everyth	ning herself! Then			
	she said she di	idn't have times (sic)			
	for games so v	we stood her up and			
	pulled up her j	pants and put her in			
	her chair! So t	hen we took her out			
	for breakfast.	After we transferred			
	<u> </u>				

NAME OF PROVIDER OR SUPPLIER WASHINGTON NURSING CENTER A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 603 EAST NATIONAL HIGHWAY WASHINGTON, IN47501)11
WASHINGTON NURSING CENTER 603 EAST NATIONAL HIGHWAY WASHINGTON, IN47501	
(VALID SUMMARY STATEMENT OF DEFICIENCIES ID	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
her (Resident #A) to the toilet (sic) (CNA #3) left (Resident #A) in the bathroom with me (CNA #1) for a minute because she had to answer an alarm and (Resident #A) asked me (why) (CNA#3) was always this way towards her and how come she was hateful. I (CNA #1) told her I really didn't know but that she should tell her nurse when someone doesn't treat her right because that wasn't fair to her and that she doesn't derserve (sic) to be treated bad." Copies of investigative sheets related to the occurrence on 03/09/11 with CNA #3 and Resident #A were provided by the DON on 03/17/11 at 11:00 a.m. Interview of LPN #2 on 03/17/11 at 1:50 p.m. indicated, "(CNA#1) had the opportunity to tell me (what took place with CNA #3 and Resident #A). LPN #2 indicated she (LPN #2) was there. LPN #2 indicated if she hadn't been there	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO	NSTRUCTION	(X	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155145	A. BUII			,	03/17/2011		
		100170	B. WIN		DDBEGG CITY OTHER CITY OCCU		00/11/2011		
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY				
WASHIN	WASHINGTON NURSING CENTER				NGTON, IN47501				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECT		(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE		
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			IAG			DATE		
	the CNA should have told another								
	nurse. LPN #2 indicated she first found out when the Therapy								
		• •							
	-	as attempting to get stand. LPN #2							
		also was trying to							
	_	resident to stand and							
	Resident #3 kept saying 'I'm afraid, I'm afraid.' LPN #2 indicated								
	CNA#3 had been taking care of								
	other residents and walked by (Resident #A) and the resident								
	•	(CNA #3) and said							
	she was afraid	of this CNA.							
	Interview of R	esident #A on							
	03/17/11 at 12	:00 p.m. indicated the							
	resident's care	was going fine. The							
	resident was si	miling and cheerful at							
	the time of the	interview. The							
	resident indica	ated there was one							
	girl" who "tal	ked mean. She had							
	_	coming out of her							
		as mad every time she							
		came in with a bad							
	attitude." The	resident indicated, "I							
		fired heryou need							
	-	view and go through							
		<i>5 6</i>							
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	YQMT12	P Facility I	D: 000068 If continua	tion shee	et Page 37 of 43		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUI	LDING		COMPL		
		155145	B. WIN			03/17/2	011	
NAME OF	PROVIDER OR SUPPLIE	3		1	ADDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY			
WASHINGTON NURSING CENTER				1	NGTONAL HIGHWAY			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	` `	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
		ent indicated at the						
	present time, '	'All the girls are real						
	nice."							
	A copy of a "I	FAX/INCIDENT						
	1	m was provided by						
		3/17/11 at 11:00 a.m						
	This report in	dicated, "Incident						
	Date - 03/06/11Staff noted a bruise approximately 14x11 cm (centimeters) on resident's upper left arm during care. Resident was							
	admitted on 1.	/22/11 with edema,						
	severe/extensi	ve bruising, a						
	fractured left	humerus (arm), and a						
	fractured left	hip as a result of a fall						
	prior to admis	sion. The resident is						
	alert with short	rt term memory						
	impairment ar	nd occasional						
	confusion. U	pon interview,						
	resident denie	s any injury to left						
	armThe Ad	ministrator and						
	Director of Nursing were notified							
	as well as the	Physician and family.						
	The resident was assessed for pain.							
	Interviews of	staff working on this						
	wing were ini	tiated. In speaking						
	with the famil	y, they stated that						
	I							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		NSTRUCTION		(X3) DATE : COMPL	ETED
		155145	B. WING		03/17/2	011		
NAME OF F	PROVIDER OR SUPPLIER	<u>L</u>	•	STREET A	DDRESS, CITY, STATE, ZII	P CODE		
				l	ST NATIONAL HIGHW	NAY		
	GTON NURSING C	ENTER		WASHIN	IGTON, IN47501			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO			(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY	ΓE	COMPLETION DATE	
IAG		bruises very easily		ING				Ditte
	,	s done so. Preventive						
		en: The Director of						
		signee will monitor						
	_	e resident and speak						
	with Physical	•						
	_	Therapy and Therapy to try to						
	_	use. The resident is						
		C (complete blood						
		ray done on 3/7/11.						
	*	·						
		py was the "initial						
	Report."							
	A convofa"	FAX/INCIDENT						
	1 2	m was provided by						
		3/17/11 at 1:00 p.m.						
		as a repeat of the						
	_	t on 03/06/11. This						
		itional information						
	which include							
		,						
	1	period, resident						
	*	one employee was						
	-	er and had used her						
		er her causing pain in						
		lent stated that she						
	was uncomfor							
	Q.M.A. (Quali							
	Assistant) (CN	JA #3 was also a						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	YQMT12	Facility II	D: 000068 If	continuation sl	heet Pa	ge 39 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/17/2011					
	NAME OF PROVIDER OR SUPPLIER WASHINGTON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 603 EAST NATIONAL HIGHWAY WASHINGTON, IN47501					
`	EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE .	(X5) COMPLETION DATE			
This on the investigation of t	was reported morning stigation directoruse on learning on the review with genurse and pleted." The Trollow-up opy of a for DISCIPLING 03/09/11 dination of cated, "# gation of vesical miscollent causing of prior when did date. It is a subject to the respectation of the prior when did the respectation of the respectation of the prior when did the p	ng ADL care on her. ted to have occurred g of 3/9/11. Further nitiated. This etly correlates with eft upper arm. physical therapy, nd co-worker were his report copy was Report." The titled "NOTICE NARY ACTION," , indicated CNA #3. The form I Repeated erbal et (and) induct toward g fear from resident. etitten warnings on 5/3/08 - attitude, to comply with ons for performance forth in employee I/inappropriate d residents (with) that further incidents							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE CO	(X	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	155145		LDING		.	COMPLETED 03/17/2011		
		100140	B. WIN		DDDDGG GIWL		00/11/2011		
NAME OF P	PROVIDER OR SUPPLIER	1		1	ADDRESS, CITY, STATE, ZIP COD ST NATIONAL HIGHWAY	DE			
WASHIN	GTON NURSING C	ENTER		1	NGTON, IN47501				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOUNDS OF THE APP CROSS-REFERENCED TO THE APP DEFICIENCY)				
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DET CHERCITY		DATE		
	may result in termination. Describe in detail information you have								
		·							
		ch supports taking the							
		of action(Resident							
	, -	ons of physical et							
	verbal inappropriateness (with)								
	same resident currently having new								
	bruising of rig	ht arm. Resident							
	expresses fear of employee"								
	Review of Res	sident #A's clinical							
	record on 03/1	7/11 at 11:25 a.m.							
	indicated the f								
	marcated the r	onowing.							
	Resident #A had diagnoses which								
		were not limited to,							
	•	ctive pulmonary							
		arthritis, dementia,							
	· ·								
		s, left hip fracture							
	1/19/11, periph								
	· ·	nic oxygen use, and							
	intra cerebral b	bleed.							
	`	imum data set)							
	assessment, dated 01/28/11, indicated Resident #A's cognitive status was moderately impaired and								
	Resident #A re	equired extensive							
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	YQMT1	2 Facility	ID: 000068 If contin	uation she	I et Page 41 of 43		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		155145	B. WING 03/17/2011					011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 603 EAST NATIONAL HIGHWAY WASHINGTON, IN47501					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLA (EACH CORRECTIVE A CROSS-REFERENCED DEFICE	TO THE APPROPRIAT	Ē	(X5) COMPLETION DATE
	and toileting.	n transfers, bathing,						
	Enterprises Pro-Abuse" was pro-on 03/17/11 at policy indicate assure approprian place and for abuse is susperidentifiedPro-abuse, or susperported: 1. To involved in the removed from onceThe individual shall be individual	cocedure: If resident icion of abuse is The resident(s) is incident will be the situation at ividual who incident shall otify a charge nurse unit which the ies. If this is not icircumstances, the Il be responsible to the incident of the circumstances is incident shall otify a charge nurse unit which the ies. If this is not icircumstances, the Il be responsible to the incident shall otify a charge nurse currently on						
	examine the red determine if pl	esident involved to hysical injuries have heir extent. The						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	YQMT12	Facility II	D: 000068	If continuation sl	neet Pa	ge 42 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155145		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/17/2011			
NAME OF PROVIDER OR SUPPLIER WASHINGTON NURSING CENTER			STREET A	ADDRESS, CITY, STATE, ZIP CODE ST NATIONAL HIGHWAY NGTON, IN47501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
	charge nurse is the facility Ad Director of Nu immediately implicated in t be removed from	s responsible to notify ministrator and arsing Any staff member the alleged abuse will tom the facility at remain suspended igation is			DATE		